MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ 03609

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 months, 2 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: ANNAPOLIS, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.F.D. #2, Box 409-A
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: GERTRUDE OZETTA ANDERSON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 9, 1926

8. AGE: Years	Months	Days	If less than one day
19	8	12	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: None
11. Industry or business:

FATHER
12. Name: Bernard Anderson
13. Birthplace: Annapolis, Md.

MOTHER
14. Maiden name: Sadie Pack
15. Birthplace: Robinson Station, Md.

16. Informant: I. B. Lyon, M. D.
Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 24, 1946 (month) (day) (year)
Cemetery or crematory: Brownswood, Md.
Location: Brownswood, Md.

18. Funeral director: J. B. Johnson
Address: 34 Lafayette Ave Annapolis Md

19. 4/21 (Date rec'd by registrar) 19 46 Albert R. Swansbrough Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 21 19 46 at 1.30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 19 19 45 to Apr. 21 19 46 and that I last saw her alive on April 21, 19 46

Immediate cause of death	DURATION
Pulmonary Tuberculosis	6 months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: I. B. Lyon M. D. ~~or other~~
Address: Henryton, Md Date signed 4/21/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

CERTIFICATE OF DEATH

03610 Reg. Dist. No. 8d

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town New Windsor
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 73 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Carroll
City or town New Windsor
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Charles Bail Bankard

3.(b) Social Security Number 213-16-7002

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Georgia Bankard
6.(c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) Dec. 20. 1872

8. AGE: Years	Months	Days	If less than one day
73	3	22	hrs. min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)
10. Usual occupation Home Painter
11. Industry or business
FATHER 12. Name David C. Bankard
13. Birthplace Carroll Co. Md.
MOTHER 14. Maiden name Elizabeth Routson
15. Birthplace Carroll Co. Md.
16. Informant (Mrs.) Blanchard Martin
Address Union Bridge, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof April 15 1946 (month) (day) (year)
Cemetery or crematory Pipe Creek Cem.
Location New Windsor, Md.
18. Funeral director H. Bankard & Son
Address Westminster, Md.
19. Apl 13 1946 (Date rec'd by registrar) Ernest D. Benedict Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1946, at 4:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 1946, to April 12 1946 and that I last saw h. alive on April 5 1946

Immediate cause of death	DURATION
Coronary Occlusion	—
Due to Arterio sclerotic Cardiovascular disease	1 yr
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James T. Mowell M. D. or other
Address Westminster Md Date signed Apr 13/46.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 89-a

CERTIFICATE OF DEATH

★03611 Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 yr., 8 mo., 13 days
Hospital, Institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 17 yr., 8 mo., 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: George Beavin, alias George F. Bevin

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Married

6.(b) Name of husband or wife: Martha E.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 25, 1871

8. AGE: Years	Months	Days	If less than one day
75	00	21	..... hrs. ..... min.

9. Birthplace: Anne Arundel County, Maryland
(Town, county, and state)
10. Usual occupation: Carpenter & stone mason
11. Industry or business:

FATHER
12. Name: Robert V. Beavin
13. Birthplace: St. Mary's County, Maryland

MOTHER
14. Maiden name: Elizabeth King
15. Birthplace: Prince George's Co., Maryland

16. Informant: Springfield State Hospital records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 20, 1946 (month) (day) (year)
Cemetery or crematory: Woodlawn Cem.
Location: Woodlawn, Md.

18. Funeral director: W. R. Selby
Address: Laurel, Md.

19. Apr. 17 1946 (Date rec'd by registrar) C. Henry Wee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 16, 1946, at 9:58 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1, 1943 to April 16, 1946 and that I last saw h... im alive on April 16, 1946

Immediate cause of death	DURATION
Cerebral hemorrhage	36 hrs.
Due to: Arteriosclerosis	2 years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May M.D.
Springfield State Hospital M. D. or other
Address: Sykesville, Maryland Date signed: 4-17-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

03612

Reg. Dist. No. 83

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: near Winfield Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs. 2 mo.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: near Winfield
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R. D. Woodbine - Md
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Joseph Wesley Bowie

3.(b) Social Security Number:

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Oct. 3, 1872
8. AGE: Years: 73 Months: 6 Days: 26 If less than one day: hrs. min.
9. Birthplace: Charles Co. Maryland (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:
FATHER 12. Name: Joseph W. Bowie
13. Birthplace: Maryland.
MOTHER 14. Maiden name: Simmons
15. Birthplace: Maryland.
16. Informant: Mrs Edna Hewitt
Address: Woodbine. Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-2-46 (month) (day) (year)
Cemetery or crematory: County
Location: Westminster. Md.
18. Funeral director: C. M. Walz
Address: Winfield. Md.
19. April 29 1946 (Date rec'd by registrar) Edna M. Hewitt Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 29 1946, at 1:10 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1944 to Death
and that I last saw h.i.m. alive on April 29 1946

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to Arteriosclerotic Heart disease	
Hypertensive cardiovascular disease	
Due to senile changes	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: J. H. Lawson. M.D. M. D. or other
Address: Dykesville Date signed 4/29/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

03613

Reg. Diat. No. 83

1. PLACE OF DEATH:

County Carroll

City or town Day

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 years

Hospital, institution, or street address where death occurred: Woodbine P.O.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll

City or town Day.

(If outside city or town limits, write RURAL and give nearest town)

Street No. Woodbine P.O.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME John Thomas Brandenburg

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Mary Elizabeth Brandenburg

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) December 31, 1878

8. AGE: Years	Months	Days	If less than one day
67	3	29	..... hrs. ..... min.

9. Birthplace Md. (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Agriculture

FATHER 12. Name Edian Brandenburg

13. Birthplace Md.

MOTHER 14. Maiden name Martha Welsh

15. Birthplace Md.

16. Informant Mrs. Mary E. Brandenburg

Address Woodbine, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 2, 1946 (month) (day) (year)

Cemetery or crematory Brandenburg Cem.

Location Berlin Parish Co., Md.

18. Funeral director C. Harry Weer

Address Sykesville, Md.

19. April 30 1946 (Date rec'd by registrar) Edna M. Hewitt Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 1946, at 4 20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 23 1946 to April 29 1946 and that I last saw him alive on April 28 1946

Immediate cause of death	DURATION
Virus Pneumonia	5 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE C. M. VanPoole M. D. or other

Address Mt Airy Md Date signed 4/29/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-C

CERTIFICATE OF DEATH

★ 03614 Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town:
(If ontside city or town limits, write RURAL and give nearest town)
Street No. 1012 N. Mount St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: CICERO BRELAND

3.(b) Social Security Number: 217-10-9690

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	married

6.(b) Name of husband or wife: Sadie Breland
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 6, 1902

8. AGE:	Years	Months	Days	If less than one day
	43	9	9	hrs. min.

9. Birthplace: Bembury, S.C.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: Dave Breland
13. Birthplace: South Carolina

MOTHER
14. Maiden name: Josephine Kiend
15. Birthplace: South Carolina

16. Informant: I.B. Lyon, M.D.
Address: Henryton, Maryland

17. Shipped (Burial, cremation, or removal. Which?) Date thereof 4-18-46 (month) (day) (year)
Cemetery or crematory
Location: Bamberg Co. S.C.
18. Funeral director: Robert E. Jennings
Address: 150 Madison Ave.

19. 4-15-46 (Date rec'd by registrar) 19 Albert R. Swanbeam Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 15, 1946 at 10:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 8, 1946 to April 15, 1946 and that I last saw him alive on April 15, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	5 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: I. B. Lyon M. D.
Address: Henryton, Md. Date signed: 4-15-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-d

03615

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH:
County: Carroll
City or town: Manchester (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 86 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Manchester (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Ida Melvin Brilhart

3.(b) Social Security Number:

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: David M. Brilhart (Deceased)
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): June 24, 1860
8. AGE: Years: 86 Months: 2 Days: 29 If less than one day: hrs. min.
9. Birthplace: Carroll Co. Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Jacob Baltzley
13. Birthplace: Maryland

MOTHER
14. Maiden name: Annamary Sellers
15. Birthplace: Maryland

16. Informant: W. C. Brilhart
Address: Manchester Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-25-46 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Manchester Md

18. Funeral director: Jacob Winkelmans Sons
Address: Manchester Md.

19. Apr. 24 1946 Mrs. W. P. J. Penner
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 23 1946 at 9:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 20 1945 to Apr 23 1946 and that I last saw h alive on April 22 1946

	DURATION
Immediate cause of death: Carcinoma Rectum	?
Due to:	
Due to:	
Other conditions: Generalized Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work? —

23. SIGNATURE: Temple E. Buckingham M. D. or other
Address: Hampstead Md Date signed: 4-23-46

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (64-3)

03616

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 days

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or Institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: —

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2639 Aisquith St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Edward Brockman

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

6.(b) Name of husband or wife: Fillian George ?

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Dec. 19, 1888

8. AGE: Years	Months	Days	If less than one day
57	4	3	____ hrs. ____ min.

9. Birthplace: Baltimore Md.
(Town, county, and state)

10. Usual occupation: Boxing Referee

11. Industry or business: Sports

FATHER
12. Name: John W. Brockman
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Lina Mueller
15. Birthplace: Baltimore, Md.

16. Informant: Hospital records
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 2, 1946 (month) (day) (year)

Cemetery or crematory: Parkwood Cem.

Location: Balto. Md.

18. Funeral director: William Cook, Jr.

Address: 1217 St. Paul St.

19. April 28 1946 (Date rec'd by registrar) C. Harry Elsey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 28 1946, at 3:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__ to ____ 19__ and that I last saw h__ alive on ____ 19__

Immediate cause of death	DURATION
Stab wounds neck, abdomen and wrists	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Stab wounds as above - perforated mesentery

Date of op. 4-25-46

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Suicide Date of 4-25-46

Where did injury occur? Sykesville (City or town) Carroll (County) Md (State)

Injured at home, farm, Industry, public place (where) Springfield State Hospital

Means of injury Stabbed self & knife Injured at work?

23. SIGNATURE: James T. Monroe Deputy Medical Examiner

Address: Westminster Md M. D. or other

Date signed: 4/28/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03617

Reg. Dist. No. 81

1. PLACE OF DEATH:

County Carroll

City or town Union Bridge Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town (Near) Union Bridge

(If outside city or town limits, write RURAL and give nearest town)

Street No. Rural

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Ida V. Buffington

3.(b) Social Security Number none

4. Sex F

5. Color or race W

6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Clarence E. Buffington

6.(c) If [illegible], give [illegible]

7. Birth date of deceased (mo., day, yr.) Sept 24, 1905

8. AGE: Years 40 Months 6 Days 28 If less than one day ... hrs. ... min.

9. Birthplace Md (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name David M. Derbiss

13. Birthplace Md

MOTHER 14. Maiden name Ida B. Etzler

15. Birthplace Md

16. Informant Clarence E. Buffington

Address Union Bridge R.D.

17. Burial Date thereof April 24 1946 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Union

Location Near Middleburg, Md.

18. Funeral director C. Bruce & Son

Address Taneytown, Md.

19. April 23 46 Leslie L. Repp (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1946, at 12 30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 24 1945, to April 21 1946

and that I last saw h alive on April 20 1946

	DURATION
Immediate cause of death Carcinoma	
Liver	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. N. Legg M. D. or other

Address Union Bridge Date signed 4-22-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

★ 03618 Reg. Dist. No. 7H

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 yr., 2 mo., 25 days
Hospital, Institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 13 yr., 2 mo., 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Charles
City or town: Unk —
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Albert Cooksey

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 22, 1870

8. AGE: Years	Months	Days	If less than one day
76	00	23	hrs. min.

9. Birthplace: Maryland
(Town, county, and state)
10. Usual occupation: farmer
11. Industry or business: agriculture

FATHER
12. Name: Hawkins Cooksey
13. Birthplace: Maryland

MOTHER
14. Maiden name: ? — Mattingly
15. Birthplace: Maryland

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/22/46 (month) (day) (year)
Cemetery or crematory: Trinity
Location: Dentsville, Md.
18. Funeral director: Hewitt & Ryon
Address: Woodbine, Md.

19 Apr. 20 1946 C. Henry Ecker Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 20 19 46 at 7:28a.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 19 43 to April 20 19 46 and that I last saw him alive on April 19 19 46

Immediate cause of death	DURATION
Senility	13 yrs.
Due to: Arteriosclerosis	13 yrs.
Due to:	
Other conditions: Psychosis with cerebral arteriosclerosis	13 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

Robert Bertrand May, M.D.
23. SIGNATURE: Robert Bertrand May MD M. D. or other
Springfield State Hospital
Address: Sykesville, Maryland Date signed: 4-20-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30

CERTIFICATE OF DEATH

★ 03619

Reg. Dist. No. 24

1. PLACE OF DEATH:

County: Carroll

City or town: rural near Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 yr., 8 mo., 24 da.

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 16 yr., 8 mo., 24 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Frederick

City or town: Frederick

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Bertram Steiner Cramer

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): 1886 ?

8. AGE: Years	Months	Days	If less than one day
60 ?	—	—	...hrs. ...min.

9. Birthplace: Frederick, Maryland (Town, county, and state)

10. Usual occupation: Hotel Clerk

11. Industry or business:

FATHER — 12. Name: Mont Knox

FATHER — 13. Birthplace: " "

MOTHER — 14. Maiden name: Susan ?

MOTHER — 15. Birthplace: Maryland

16. Informant: Springfield State Hosp. records

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-15-46 (month) (day) (year)

Cemetery or crematory: Mt. Olivet Cemetery

Location: Frederick Md.

18. Funeral director: C. E. Cline & Son

Address: Frederick, Md.

19. April 18 1946 (Date rec'd by registrar) C. Henry Weed Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 12 1946 at 11:50 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1943, to April 12 1946

and that I last saw him alive on April 11 1946

Immediate cause of death	DURATION
General paralysis of insane	19 yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert Bertrand May, M.D.

Springfield State Hospital M. D. or Other

Address: Sykesville, Maryland Date signed: 4-12-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03620

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 months, 3 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest towo)
Street No. 1818 Woodyear Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: EARL THEODORE DAVIS

3.(b) Social Security Number: 215-22-1416

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 19, 1928

8. AGE: Years	Months	Days	If less than one day
18	0	8	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: In Merchant Marines
11. Industry or business

FATHER
12. Name: Floyd Davis
13. Birthplace: Charlotte, Va

MOTHER
14. Maiden name: Bessie Peters
15. Birthplace: Charlotte, Va.

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-30-46 (month) (day) (year)
Cemetery or crematory: Mt Auburn
Location: Baltimore, City
18. Funeral director: Geo L Kelson
Address: 1303 Pressman. St.

19. 4/27 (Date rec'd by registrar) 1946 Albert R. Scrunkhorn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 27, 1946, at 11.40 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 24 1945 to April 27, 1946
and that I last saw him alive on April 27 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	9 months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. A. Lyon
M. D. or other
Address: Henryton, Md. Date signed: 4/27/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (19-2)

03621

P

CERTIFICATE OF DEATH

Reg. Dist. No. 7 Y

1. PLACE OF DEATH:

County Carroll

City or town Springfield State Hospital, Sykesville, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 yrs., 11 mos., 4 days

Hospital, institution, or street address (where death occurred):
Springfield State Hospital

How long in hospital or institution? 7 yrs., 11 mos., 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Baltimore City

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1022 Biddle St.
(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME James Driscoll

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Aug. 29, 1909

8. AGE: Years 36 | Months 7 | Days 9 | If less than one day ____ hrs. ____ min.

9. Birthplace Baltimore City, Md.
(Town, county, and state)

10. Usual occupation Western Union messenger

11. Industry or business

FATHER 12. Name Dennis Driscoll

13. Birthplace Ireland

MOTHER 14. Maiden name Delia Ballard

15. Birthplace Ireland

16. Informant Mrs. Dennis Driscoll

Address 2857 Lake Ave., Baltimore, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 9 1946 (month) (day) (year)

Cemetery or crematory Cathedral

Location Baltimore

18. Funeral director Rita Wiedefeld

Address 914 Greenmount Ave

19. 4/9 1946 D.W. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7, 1946, at 3:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 11 1946, to April 7 1946 and that I last saw him alive on April 6 1946

Immediate cause of death	DURATION
Pulmonary tuberculosis	two (2) years
Due to	
Due to	
Due to	
Other conditions Schizophrenia, hebephrenic type	10 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations ____ Date of op. ____

Autopsy results ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE Joseph H. Marshall, M.D.
M. D. or other

Address Springfield State Hospital Date signed 4/7/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

03622

CERTIFICATE OF DEATH

Reg. Diat. No. 24

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs 9 mos 24 da

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 3 yrs 9 mos 24 da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) Ll veteran, name war:

3. (a) FULL NAME: Elva Grace Eyler

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife: Edward J. Eyler

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 9th - 1885

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
60	9	—		

9. Birthplace: Pa (Town, county, and state)

10. Usual occupation: House work

11. Industry or business: at home

FATHER — 12. Name: David W. Musser

FATHER — 13. Birthplace: Pa

MOTHER — 14. Maiden name: Sarah Gaither

MOTHER — 15. Birthplace: Pa

16. Informant: Owen Eyler

Address: 138 W. Baltimore St Hagerstown

17. Removal (Burial, cremation, or removal. Which?) Date thereof 4-9-1946 (month) (day) (year)

Cemetery or crematory: Green Hill Cemetery

Location: Near Waynesboro Pa

18. Funeral director: Walter L. Grove

Address: Waynesboro Pa

19. Apl 9 1946 (Date rec'd by registrar) C. Harry Wees Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 9th 1946 at 8-15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15th 1942 to Apr. 9th 1946 and that I last saw h.. alive on April 9th 1946

Immediate cause of death	DURATION
Chronic Myocarditis	4 yrs
Due to: Arteriosclerosis	4 yrs
Due to: Hypertension	4 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. F. Gaston M.D. M. D. or other

Address: Sykesville Md Date signed: 4/9/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03623

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: St. Mary's
City or town: Ridge
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Wynne
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: GERTRUDE FORD

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	married

6.(b) Name of husband or wife: Joseph Ford
6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): October 18, 1898

8. AGE:	Years	Months	Days	If less than one day
	47	5	26	hrs. min.

9. Birthplace: Wynne, Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: Frank Briscoe
13. Birthplace: St. Mary's County, Md.

MOTHER
14. Maiden name: Ellen Briscoe
15. Birthplace: Leonardtown, Md.

16. Informant: I. B. Lyon, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4-17-46 (month) (day) (year)
Cemetery or crematory: St Peters.
Location: Ridge Md.

18. Funeral director: E. L. Robinson
Address: Leonardtown Md

19. April 14, 1946 (Date rec'd by registrar) Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 14, 1946, at 9:05 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 14, 1946, to April 14, 1946 and that I last saw her alive on April 14, 1946

Immediate cause of death	DURATION
Congestive Cardiac Failure	2 months
Due to	
Due to	
Other conditions: Pulmonary Tuberculosis	4 months

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: I. B. Lyon M. D.
Address: Henryton, Md. Date signed: 4-14-46

Original sent to State Department of Health

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

03624

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1618 Druid Hill Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: PETER GARRETT

3.(b) Social Security Number: 212-05-5242

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 24, 1904

8. AGE:	Years	Months	Days	If less than one day
	41	6	7	hrs. min.

9. Birthplace: Lexington, Va. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: Peter Garrett, Sr.
13. Birthplace: Middlesex Co., Va.

MOTHER
14. Maiden name: Emma Jones
15. Birthplace: Middlesex Co., Va.

16. Informant: I.B. Lyon, M.D.
Address: Henryton, Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof 4/4/46 (month) (day) (year)
Cemetery or crematory: Arbutus Memorial Park
Location:

16. Funeral director: Mrs. George H. Holland
Address: 1631 Druid Hill Ave.

19. 4/1 (Date rec'd by registrar) 19 46 Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 1, 19 46 at 1:55P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 22, 19 46 to April 1, 19 46 and that I last saw him alive on April 1, 19 46

Immediate cause of death: Pulmonary Tuberculosis — DURATION: About 3 months
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: I. B. Lyon M. D. or other
Address: Henryton, Md. Date signed: 4-1-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9352)

03625

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 3 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Angelina Glorioso

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Married.

6.(b) Name of husband or wife: Salvatore Glorioso

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jul 28 - 1884

8. AGE: Years	Months	Days	If less than one day
62	9	16	hrs. min.

9. Birthplace: Sicily - Italy

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: at home

FATHER 12. Name: Frank Cufolta

13. Birthplace: Italy

MOTHER 14. Maiden name: Unk

15. Birthplace:

16. Informant: Mrs C Jonski

Address: 4505 Roslyn Ave Balto

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-20-46 (month) (day) (year)

Cemetery or crematory: New Cathedral Cem.

Location: Balto. Md.

18. Funeral director: Wm Cook, Inc.

Address: 1217 N. Paul St.

19. April 16 1946 (Date rec'd by registrar) C. Haywood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 16 1946 at 4:05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 28 1943 to April 16 1946 and that I last saw h alive on April 16 1946

Immediate cause of death	DURATION
Terminal Bronchopneumonia 2 da	
Due to: Chronic Hypertension 3 yrs	
Due to: Senile Arterio Sclerosis 6 yrs	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. J. Gaston M.D. M. D. or other

Address: Sykesville Md. Date signed: 4/16/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

63626

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 yrs 3 mo 4 da.

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 20 yrs 3 mo 4 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Wash.

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 105 East Howard Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: LOLA HAMMERSLA

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Walter W Hammersla

6.(c) If alive, give age: unknown years

7. Birth date of deceased (mo., day, yr.): March 27, 1891

8. AGE: Years	Months	Days	If less than one day
55	0	29	hrs. min.

9. Birthplace: West Virginia
(Town, county, and state)

10. Usual occupation: none

11. Industry or business: none

FATHER
12. Name: Dr. Albert Zimmerman
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Fannie C. Barney
15. Birthplace: West Virginia

16. Informant: Hospital Records

Address: Sykesville, Maryland

17. ~~Le~~ Burial (Burial, cremation, or removal. Which?) Date thereof: April 27, 1946 (month) (day) (year)

Cemetery or crematory: Lorraine Cemetery

Location: Kinsdale Mill Rd.

18. Funeral director: Elmer H. Conklin & Son

Address: 924 E. Eager St. Balto. Md

19. 4/27 1946 (Date rec'd by registrar) A.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 25, 1946, at 8.30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1, 1946, to April 25, 1946

and that I last saw him/her alive on April 24 1946

Immediate cause of death	DURATION
Tuberculosis of the Lungs	more than 3 months
Due to:	
Due to:	
Other conditions: Schizophrenia--paranoid type	30 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Dr. Maud M. Rees M. D. or other

Address: Sykesville, Md. Date signed: 4-25-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

03627

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 yr., 11 mo., 8 days
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 15 yr., 11 mo., 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Geo.
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Frank Hardy

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 10, 1864

8. AGE: Years	Months	Days	If less than one day
81	4	22	hrs. min.

9. Birthplace: New Hampshire
(Town, county, and state)
10. Usual occupation: laborer
11. Industry or business

FATHER
12. Name: Alfred Hardy
13. Birthplace: Massachusetts

MOTHER
14. Maiden name: Elizabeth Swett
15. Birthplace: Massachusetts

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-12-46 (month) (day) (year)
Cemetery or crematory: Springfield Hosp. Cem.
Location: Sykesville, Md.
18. Funeral director: C. Harry Weed
Address: Sykesville, Md.
19. April 12 1946 (Date rec'd by registrar) C. Harry Weed Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 2 1946, at 12:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1943 to April 2 1946 and that I last saw him alive on April 2 1946

Immediate cause of death	DURATION
Bronchopneumonia	4 days
Due to	
Due to	
Other conditions: Schizophrenia, paranoid type in a mental defective (Incinde pregnancy within 3 months of death)	40 yrs.

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert Bertrand May, M.D.
Address: Springfield State Hospital Sykesville, Maryland M.D., or other
Date signed: 4-3-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

03628

★ Reg. Dist. No. 75

1. PLACE OF DEATH:

County: Carroll

City or town: Manchester Md Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 Wks.

Hospital, Institution, or street address where death occurred: Mullins Rd.

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Manchester Md - Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Mullins Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Isaac Emory Hare

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Carrie Hare

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Aug 16 1868

8. AGE: Years: 77 | Months: 7 | Days: 28 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Maryland (Town, county and state)

10. Usual occupation: Retired Farmer

11. Industry or business: Agriculture

FATHER — 12. Name: Abraham Hare

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Mary Hampshire

MOTHER — 15. Birthplace: Maryland

16. Informant: Mrs Emily Lyons

Address: Manchester, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 16/46 (month) (day) (year)

Cemetery or crematory: Grave Run

Location: Balto Co Md

18. Funeral director: Edw C Tipton

Address: Hampstead Md

19. Apr. 13 1946 (Date rec'd by registrar) Mrs. W. R. S. Benner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 13 1946 at 6 35 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 1. 1940 to April 13 1946 and that I last saw him alive on April 13 1946

Immediate cause of death	DURATION
Coronary Occlusion	2 hrs
Due to: Chronic Hypocarditis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of ____

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury — Injured at work? —

23. SIGNATURE: Edgar M. Buck M.D. M. D. or other

Address: Hampstead Md Date signed: 4-13-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03629

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 yrs. 1 mo's, 22 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1503 Jefferson Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: VERNELLE HORNS

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	Married

6.(b) Name of husband or wife: Lee Andrew Horns
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 21, 1921

8. AGE: Years	Months	Days	If less than one day
24	7	7	hrs. min.

9. Birthplace: Halifax, N. C.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Will Parker
13. Birthplace: Norfolk, Virginia

MOTHER
14. Maiden name: Mary Francis
15. Birthplace: Halifax, N. Carolina

18. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/3/1946 (month) (day) (year)
Cemetery or crematory: Mt. Columbia
Location:
18. Funeral director: Adolphus Hasty
Address: 918 Druid Hill Ave

19. 4/28 (Date rec'd by registrar) 19 46 Albert R. Swandale Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 28, 1946, at 11:10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 6, 1942, to April 28, 1946
and that I last saw her alive on April 28, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	4½ yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: D. B. Lyon M. D. or other
Address: Henryton, Md Date signed: 4/28/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03630

Reg. Dist. No. 74

M.

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 616 W. Fairmount Ave.
(If rurol, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: ROOSEVELT HORSSEY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	married

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 10, 1902

8. AGE: Years	Months	Days	If less than one day
43	10	9	hrs. min.

9. Birthplace: Pocomoke City, Md. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:
FATHER 12. Name: Bill Horssey
13. Birthplace: Unknown
MOTHER 14. Maiden name: Mary Hargis
15. Birthplace: Pocomoke City, Md.
18. Informant: Deceased
Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof 4-20-46 (month) (day) (year)
Cemetery or crematory: Balto. City Morgue
Location:
18. Funeral director: Mrs. Samuel I. Hemsley
Address: 578 W. Biddle St., Balto. Md.
19. April 19, 19 46 (Date rec'd by registrar) Albert R. Swanbeam Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 19, 19 46, at 3:40P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 9, 19 46 to April 19, 19 46 and that I last saw him alive on April 19, 19 46

Immediate cause of death	DURATION
Pulmonary Tuberculosis	5 months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to exfernal causes, fill in the followiog:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. B. Lyon M. D.
Address: Henryton, Md. Date signed: 4-19-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03631

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 months, 11 days
Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1804 McCulloh St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: SAMUEL EDWARD HYMAN

3.(b) Social Security Number: 705-07-7902

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	married

6.(b) Name of husband or wife: Grace Hyman
6.(c) If alive, give age: 32 years

7. Birth date of deceased (mo., day, yr.): September 8, 1910

8. AGE: Years	Months	Days	If less than one day
35	7	16	...hrs. ...min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:
FATHER — 12. Name: Henry Hyman
13. Birthplace: Winston Salem, N.C.
MOTHER — 14. Maiden name: Rosetta Thomas
15. Birthplace: Matthews, Va.
16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-29-46 (month) (day) (year)
Cemetery or crematory: Mt. Auburn
Location: Baltimore City
18. Funeral director: Geo. L. Kelson
Address: 1303 Eastern Ave.

19. April 24, 1946 (Date rec'd by registrar) Albert R. Swackhamer Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 24, 1946, at 9:45A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 13, 1945, to April 24, 1946
and that I last saw h... im alive on April 24, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	2 yrs., & 5 mo's
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: ... Injured at work?

23. SIGNATURE: D. B. Lyon M. D. or Coroner
Address: Henryton, Md. Date signed: 4-24-46

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

03632

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months, 22 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Upper Marlboro,
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.R. #2
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: ABRAHAM JONES

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	married

6.(b) Name of husband or wife: Hazel Jones
6.(c) If alive, give age: 33 years

7. Birth date of deceased (mo., day, yr.): Feb. 13, 1913

8. AGE: Years	Months	Days	If less than one day
33	1	23	....hrs. ....min.

9. Birthplace: Upper Marlboro, Md. (Town, county, and state)
10. Usual occupation: Farm Laborer
11. Industry or business

FATHER
12. Name: Benjamin Jones
13. Birthplace: Upper Marlboro, Md.

MOTHER
14. Maiden name: Mamie Wright,
15. Birthplace: Anne Arundel County, Md.

16. Informant: I.B. Lyon, M.D.
Address: Henryton, Maryland

17. (Burial, cremation, or removal. Which?) Burial Date thereof (month) 4 (day) 8 (year) 46
Cemetery or crematory: Walkers Chapel
Location: Drury, Md.
18. Funeral director: T. A. Hardesty & Son
Address: Galesville, Md.

19. (Date rec'd by registrar) April 6, 1946
Albert R. Swackhamer Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 6, 1946, at 9:00A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 14, 1946, to April 6, 1946
and that I last saw him alive on April 6, 1946

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	4 months
Due to: Pulmonary Hemorrhage	½ hour
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: I. B. Lyon M. D. or other
Address: Henryton, Md. Date signed: 4-6-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03633

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll Co

City or town [redacted] Louisville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll Co

City or town Louisville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Carl E Kallenbach

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	married.

6.(b) Name of husband or wife Hedwig Kallenbach

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 25 1871

8. AGE:

Years	Months	Days	If less than one day
74	7 8		..... hrs. ..... min.

9. Birthplace Germany (Town, county, and state)

10. Usual occupation Retired Baker

11. Industry or business Bakery

FATHER 12. Name Martin Kallenbach

13. Birthplace Germany.

MOTHER 14. Maiden name Eliza Roeder

15. Birthplace Germany

16. Interment Mrs. Carl E Kallenbach

Address Sykesville R.F.D. #1.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/26/46 (month) (day) (year)

Cemetery or crematory Woodlawn

Location Reese City Md.

18. Funeral director Edw. S. MacNabb

Address Catonsville Md.

19. 4/23 1946 (Date rec'd by registrar) A.W. Hedrick Registrar

D.M.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1946, at 10.40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 24 1946, to April 24 1946

and that I last saw him alive on April 24 1946

Immediate cause of death	DURATION
Angina Pectoris	
Due to	
Due to	
Other conditions Cardiac Paralysis	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Frank Turner, M.D. M. D. or other

Address Sykesville Md. Date signed 4-27-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-B)

03634

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr. 4 mo's. 29 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 631 N. Paca Street (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: MARGARET KEELS

3.(b) Social Security Number: 219-22-1774

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 23, 1923

8. AGE: Years	Months	Days	If less than one day
22	9	23	hrs. min.

9. Birthplace: Olanta, S. C. (Town, county, and state)
10. Usual occupation: Laundry Worker
11. Industry or business:

FATHER
12. Name: Zeak Keels
13. Birthplace: South Carolina

MOTHER
14. Maiden name: Annie Liza
15. Birthplace: Turbeville, S. C.

16. Informant: I. B. Lyon, M. D.
Address: Henryton, Md.

17. Shipped (Burial, cremation, or removal. Which?) Date thereof 4-19-46 (month) (day) (year)
Cemetery or crematory:
Location: Sumter, S. C.
18. Funeral director: Rodolphus Halstead
Address: 918 Dennis Bill Ave.

19. April 16, 1946 (Date rec'd by registrar) Albert E. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 16, 1946, at 7.45A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 17, 1944, to April 16 1945
and that I last saw her alive on April 16 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	18 months
Tuberculous Enteritis	4 months
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: I. B. Lyon M. D.
Address: Henryton, Md. Date signed: 4-16-46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03635

Reg. Dist. No. 7K

P

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 months, 12 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 7 months, 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore City

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 108 South Durham Street, Baltimore
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Irene Kennedy (or) Kaniecka (or) Kaniecki (or) Karriecky

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 12/12/26

8. AGE: Years	Months	Days	If less than one day
19	4	8	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: William Kennedy
13. Birthplace: Poland

MOTHER
14. Maiden name: Ella Antocieski
15. Birthplace: Poland

16. Informant: Miss Alvina Kennedy

Address: 108 South Durham Street, Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/23/46 (month) (day) (year)

Cemetery or crematory: St. Stanislaus Cem.

Location: Dundalk Ave.

18. Funeral director: M. W. K. Oppel's Sons

Address: Lombard & Ann Sts.

19. 4/22 19 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4/19 19 46, at 11:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/8 19 45, to 4/19 19 46 and that I last saw her alive on 4/19 19 46

	DURATION
Immediate cause of death: Insulin shock	6 hours
Due to: Diabetes Mellitus	?
Due to:	
Other conditions: Mental deficiency without psychosis,	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Eichat, M.D.
M. D. or other

Address: Sykesville, Maryland Date signed: 4/20/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03636

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yr., 9 mo., 16 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 3 yr., 9 mo., 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Lawrence Knapp

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	divorced

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 22, 1882

8. AGE: Years	Months	Days	If less than one day
63	7	18	hrs. min.

8. Birthplace: Germany
(Town, county, and state)
10. Usual occupation: storekeeper
11. Industry or business: retail grocery

FATHER
12. Name: Morritz Knapp
13. Birthplace: Germany

MOTHER
14. Maiden name: Zorn Christine
15. Birthplace: Germany

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 12, 1946 (month) (day) (year)
Cemetery or crematory: Holy Redeemer
Location: Balto. Md.

18. Funeral director: Tilley & Zeeler Inc.
Address: 403 N. Eutaw St.

19. April 10 1946 (Date rec'd by registrar) C. Henry Dear Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 10, 1946, at 5:20a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1, 1943 to April 10, 1946 and that I last saw him alive on April 9, 1946

Immediate cause of death	DURATION
Cerebral hemorrhage	8 hrs.
Due to: Arteriosclerosis, prior to	1940
Due to:	
Other conditions: Psychosis with cerebral arteriosclerosis	6 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May, MD
Address: Springfield State Hospital, Sykesville, Maryland M. D. or other
Date signed: 4-10-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

03638

Reg. Dist. No. 24

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 years, 2 months.
Hospital, institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 8 years, 2 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Westernport
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Joseph Aloysius Lennan

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 9, 1886

8. AGE: Years	Months	Days	If less than one day
59	10	00	..... hrs. ..... min.

9. Birthplace: Westernport, Maryland (Town, county, and state)
10. Usual occupation: clerk
11. Industry or business: railroad
FATHER 12. Name: Joseph Lennan
FATHER 13. Birthplace: Ireland
MOTHER 14. Maiden name: Katherine Gertrude Hanley
MOTHER 15. Birthplace: Frankville, Maryland
16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 12, 1946 (month) (day) (year)
Cemetery or crematory: Westernport
Location: Allegany Co., Md.
18. Funeral director: D. T. C. Beal
Address: Westernport, Md.

19. April 9 1946 (Date rec'd by registrar) C. Harry Esser Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 9, 1946, at 4:00a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1, 1943 to April 9, 1946 and that I last saw him alive on April 8, 1946

Immediate cause of death	DURATION
Injured by fall; fracture of left hip	2 mos.
Due to	
Due to	
Other conditions: Manic-depressive psychosis (Include pregnancy within 3 months of death)	14 yrs.

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: 2-9-46
Where did injury occur? Sykesville, Carroll, Md. (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): mental hospital
Means of injury: fall Injured at work? no

Robert Bertrand May, M.D.
23. SIGNATURE: Robert Bertrand May, M.D.
Springfield State Hospital M. D. or other
Address: Sykesville, Maryland Date signed: 4-9-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

03639 74
Reg. Diat. No.

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 months, 12 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Worcester
City or town Berlin
(If outside city or town limits, write RURAL and give nearest town)
Street No. Davis Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: MAE LOUISE LEONARD

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1923

8. AGE: Years	Months	Days	If less than one day
22	11	0	hrs. min.

9. Birthplace Berlin, Md.
(Town, county, and state)
10. Usual occupation Factory Worker
11. Industry or business
MOTHER FATHER
12. Name John Leonard
13. Birthplace Berlin, Md.
MOTHER
14. Maiden name Minnie Purnell
15. Birthplace Berlin, Md.
16. Informant I. B. Lyon, M.D.
Address Henryton, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-11-46 (month) (day) (year)
Cemetery or crematory St Pauls
Location Berlin Md.
18. Funeral director J. W. Burbage Funeral Home
Address Berlin, Md
19. April 6, 1946 (Date rec'd by registrar) Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6, 1946, at 7:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 24, 1945 to April 6, 1946
and that I last saw her alive on April 6, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	7 months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE I. B. Lyon M. D. or Other
Address Henryton, Md. Date signed 4-6-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03640

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 months, 14 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1704 Brentwood Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: EMMA LEVY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	widowed

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 2, 1917

8. AGE:

Years	Months	Days	If less than one day
28	4	12	hrs. min.

9. Birthplace: Gloucester County, Va.
(Town, county, and state)

10. Usual occupation: Laundry Worker

11. Industry or business

FATHER 12. Name: Joshua Harris

13. Birthplace: Gloucester Co., Va.

MOTHER 14. Maiden name: Pauline Smith

15. Birthplace: Gloucester Co., Va.

16. Informant: I.B. Lyon, M.D.

Address: Henryton, Maryland

17. Shipped (Burial, cremation, or removal. Which?) Date thereof 4/17/46 (month) (day) (year)

Cemetery or crematory: Gloucester

Location: Gloucester, Virginia

18. Funeral director: Laymen Sanders

Address: 1412 E. Preston Street

19. April 14, 1946 (Date rec'd by registrar) Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 14, 1946, at 3:55P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 30, 1945 to April 14, 1946 and that I last saw her alive on April 14, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	2 years
Tuberculous Enteritis	9 months
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: I.B. Lyon M. D. or other

Address: Henryton, Md. Date signed: 4-14-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

03637

Reg. Diat. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: CARROLL

City or town: RURAL WESTMINSTER (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? LIFE

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: MARYLAND County: CARROLL

City or town: RURAL WESTMINSTER (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: ARTHUR J. LOCKARD

3. (b) Social Security Number: 220-03-8786

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife: SARAH E. LOCKARD

6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): MAY 6, 1881

8. AGE: Years	Months	Days	If less than one day
64	11	3	..... hrs. ..... min.

9. Birthplace: CARROLL COUNTY, MARYLAND (Town, county, and state)

10. Usual occupation: FARMER

11. Industry or business

FATHER 12. Name: JOSHUA LOCKARD

FATHER 13. Birthplace: MARYLAND

MOTHER 14. Maiden name: MARY LAMBERT

MOTHER 15. Birthplace: MARYLAND

16. Informant: MRS. CHARLES BITZEL

Address: WESTMINSTER, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/13/46 (month) (day) (year)

Cemetery or crematory: DEER PARK CEMETERY

Location: SMALLWOOD, MD.

16. Funeral director: J. FRANCIS REESE

Address: WESTMINSTER, MD.

19. 4/11 (Date rec'd by registrar) 19 46 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: APRIL 9 19 46, at 7:50 p.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 19 45 to Apr. 9 19 46 and that I last saw h... alive on April 9 - 19 46

Immediate cause of death	DURATION
Cerebral hemorrhage	10 days
Due to	
Due to Hypertension	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W. C. Jennelle M.D.

M. D. or other

Address: Westminster Date signed

03641

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

03641

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 19 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Turners Station
(If outside city or town limits, write RURAL and give nearest town)
Street No. 100 Sollars Point Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: LUCRETIA MACKLIN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	married

6.(b) Name of husband or wife: Frederick Macklin
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 15, 1918

8. AGE:	Years	Months	Days	If less than one day
	27	10	25	hrs. min.

9. Birthplace: Mackinburg, Va. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Llewelyn Wynn
13. Birthplace: Virginia

MOTHER
14. Maiden name: Carrie Macklin
15. Birthplace: Virginia

16. Informant: I. B. Lyon, M.D.
Address: Henryton, Maryland

17. (Burial, cremation, or removal. Which?) Burial Date thereof: 4-16-46 (month) (day) (year)
Cemetery or crematory: La Leonard, Va.
Location: Mecklenburg Co., Va.

18. Funeral director: H. G. Jackson
Address: 916 Penna. Ave. N.W.

19. April 10, 1946 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 10, 1946, at 1:15P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 21, 1946, to April 10, 1946 and that I last saw her alive on April 10, 1946

Immediate cause of death	DURATION
Tuberculous Peritonitis	4 months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: I. B. Lyon M. D. ~~or other~~
Address: Henryton, Maryland Date signed: 4-10-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (176)

CERTIFICATE OF DEATH

03642 76
Reg. Diat. No.

1. PLACE OF DEATH:
County: Carroll
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? [redacted]
Hospital, Institution, or street address where death occurred: 16 Main St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Westminster Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Uniontown Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Frank David McKinney Jr.

3.(b) Social Security Number: 219-14-8028

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Helen J. McKinney
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 29-1922

8. AGE: Years: 23 | Months: 9 | Days: 3 | If less than one day: hrs. min.

9. Birthplace: Frederick County, Md
(Town, county, and state)

10. Usual occupation: miller

11. Industry or business: Feed mill

FATHER
12. Name: Frank D. McKinney Sr.
13. Birthplace: Maryland

MOTHER
14. Maiden name: Pauline Stover
15. Birthplace: Maryland

16. Informant: Mrs. Helen J. McKinney
Address: Westminster Md. R. 10

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 4-1946 (month) (day) (year)
Cemetery or crematory: Meadow Branch Cem
Location: Westminster R. 9. Md.

18. Funeral director: C. H. Hawkins & Sons
Address: Union Bridge & Westminster Md

19. apr 2 1946 (Date rec'd by registrar) Ray Fogle Dep Reg Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 1 1946 at 8:45A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from [redacted] 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Suffocation	
Due to: Crushing injury to Chest	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.:

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: Apr. 1-1946
Where did injury occur? Westminster (City or town) Carroll (County) Md (State)
Injured at home, farm, industry, public place (where?) Farmers Feed Elevator and Feed Co
Means of injury: Caught in elevator Injured at work? Yes

23. SIGNATURE: James T. Mansell Deputy Medical Examiner
M. D. or other
Address: Westminster Md Date signed: Apr. 1-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

03643 Reg. Dist. No. 70

1. PLACE OF DEATH:
County Carroll
City or town Taneytown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Taneytown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Robert Sentman McKinney

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Maggie Belle Galt
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) November 27, 1860

8. AGE: Years	Months	Days	If less than one day
85	4	22	..... hrs. ..... min.

9. Birthplace Taneytown, Carroll County, Maryland
(Town, county, and state)
10. Usual occupation Pharmacist
11. Industry or business

FATHER
12. Name Andrew McKinney
13. Birthplace Maryland

MOTHER
14. Maiden name Sarah Ann Catherine Sentman
15. Birthplace Penna.

16. Informant Mrs. Harry Reindollar
Address Taneytown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 21, 1946 (month) (day) (year)
Cemetery or crematory Evergreen Cemetery
Location Gettysburg, Pa.

18. Funeral director C.O.Fuss & Son
Address Taneytown, Md.

19. April 22 19 46 Ethel M Mehring
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 19 46 at 4:02 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 9 19 41, to April 18 19 46 and that I last saw him alive on April 18 19 46

Immediate cause of death	DURATION
Chronic myocarditis and myocardial degeneration	10 yrs.
Due to (non-rheumatic)	
Due to	
Other conditions Chronic nephritis, Generalized arteriosclerosis, Benign prostatic hypertrophy. (Include pregnancy within 3 months of death)	

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE R. S. McVaugh M. D.
M. D. or other
Address Taneytown, Md. Date signed 4.18.46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

03644

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 yr. 9 mo 25 da
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 9 yrs. 9 mo. 25 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 301 Whitridge Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME IRENE AGNES MC WHIRTER

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 17, 1887 (1887)

8. AGE: Years	Months	Days	If less than one day
58	11	3	hrs. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)
10. Usual occupation none
11. Industry or business none

FATHER
12. Name William McWhirter
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden name Jane (unknown) Connor
15. Birthplace Virginia

16. Informant Hospital Records
Address Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4 - 24 - 46 (month) (day) (year)
Cemetery or crematory Mt Olivet Cem.
Location Balto. Md.
18. Funeral director Stewart & Mowen Co.
Address 108 W. Mobtholme Ave.

19. Apr. 20 1946 C. Harry Warr
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20, 1946, at 3.45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 17 1937, to Apr. 20 1946 and that I last saw her alive on Apr. 20, 1946

Immediate cause of death	DURATION
Carcinoma of the stomach	5 yrs.
Due to	
Due to	
Other conditions Schizophrenia--paranoid type	29 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Mary M. Rees M.D.
M. D. or other
Address Sykesville, Md. Date signed 4-20-46

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS A15

03645

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Woodbine MD. Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Woodbine MD. Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Maltilda Moles

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: James [illegible] Moles [illegible]
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 12 1869

8. AGE: Years	Months	Days	If less than one day
76	10	4	..... hrs. ..... min.

9. Birthplace: Sheedsville Tenn
(Town, county, and state)
10. Usual occupation: None
11. Industry or business: None

FATHER
12. Name: James Epperson
13. Birthplace: Tenn

MOTHER
14. Maiden name: Gabe[illegible] Emerson
15. Birthplace: Tenn[illegible]

16. Informant: George V. Davis
Address: Woodbine MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 19 1946 (month) (day) (year)
Cemetery or crematory: Mt. Tabor
Location: Etchison MD.

18. Funeral director: Roy W. Barber
Address: Laytonsville MD.

19. Apr 17 1946 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 16, 1946, at 5.15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1945 to April 16 1946
and that I last saw [illegible] alive on April 15 1946

Immediate cause of death	DURATION
Uremia	
Due to Tabular Heart Disease	
Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: W. A. Barber MD
M. D. or other
Address: Sykesville MD. Date signed 4/17/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS/A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

03646

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 months, 23 days

Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 1307 E. Monument Street (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: DOROTHY JONES MONDOWNEY

3.(b) Social Security Number: 213-18-1965

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	Divorced

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 23, 1921

8. AGE:

Years	Months	Days	If less than one day
24	10	4	hrs. min.

9. Birthplace: Eastville, Va. (Town, county, and state)

10. Usual occupation: Defense Worker

11. Industry or business

FATHER — 12. Name: Grnets Booth

13. Birthplace: Hampton Virginia

MOTHER — 14. Maiden name: Alberta Jones

15. Birthplace: Morehead City, N. C.

16. Informant: Deceased

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 1, 1946 (month) (day) (year)

Cemetery or crematory: Mt Calvary Cem.

Location

18. Funeral director: Elroy O. Wilson

Address: 1000 Saintly ave

19. 4/27 (Date rec'd by registrar) 1946 Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 27, 1946, at 10.55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 4, 1945 to April 27, 1946 and that I last saw her alive on April 27, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	14 months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: D. B. Lyon M. D. ~~or other~~

Address: Henryton, Md. Date signed: 4/27/46

03647

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 6 days
Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Stockton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: SEWELL STEWART MURRAY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 25, 1925

8. AGE: Years	Months	Days	If less than one day
21	2	24	..... hrs. ..... min.

9. Birthplace: New Church, Va. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: William Murray
13. Birthplace: Washington, D.C.

MOTHER
14. Maiden name: Stella Custis
15. Birthplace: Virginia

16. Informant: I.B. Lyon, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-21-46 (month) (day) (year)
Cemetery or crematory: Woodlawn Cem.
Location: Pocomoke City, Md.

18. Funeral director: Dennis Funeral Home
Address: Pocomoke City, Md.

19. April 19, 1946 (Date rec'd by registrar) Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 19, 1946, at 11:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 13, 1946, to April 19, 1946 and that I last saw him alive on April 19, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	5 months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: I. B. Lyon M. D. or other
Address: Henryton, Md. Date signed: 4-19-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

03648 74

Reg. Dist. No.

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 26 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital.

How long in hospital or institution? 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: ----

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1320 Greenmount Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: EDNA MARIE MYERS

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	widow

6.(b) Name of husband or wife: Ernest Myers

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): August 10, 1914

8. AGE: Years	Months	Days	If less than one day
31	8	17	..... hrs. ..... min.

9. Birthplace: Baltimore, Md
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: own home

FATHER
12. Name: Roger Thomas Kinnatt
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Mary Kelly
15. Birthplace: Baltimore, Md.

16. Informant: Hospital Records
Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 1, 1946 (month) (day) (year)
Cemetery or crematory: New Cathedral Cem.
Location: Balto. Md.

18. Funeral director: William Rook, Inc.
Address: 1217 N. Paul St.

19. April 28 1946 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 27 1946 at 10:15P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-2-46 19..... to 4-27-46 19..... and that I last saw h...er alive on 4-27-46 19.....

Immediate cause of death	DURATION
Pulmonary Tuberculosis	1½ yrs.
Due to	
Due to	
Other conditions //////////////////	
Chronic Alcoholism (Include pregnancy within 3 months of death)	unknown

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Arnold H. Eichert M.D.
M. D. or other

Address: Sykesville, Md. Date signed: 4-28-46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

03649

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 months, 17 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 503 N. Stricker Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: JAMES OSCAR NORRIS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	married

6.(b) Name of husband or wife: Dorothy Norris
B.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 25, 1907

8. AGE: Years	Months	Days	If less than one day
38	6	1	hrs. min.

9. Birthplace: Nettesville, Va.
(Town, county, and state)

10. Usual occupation: Longshoreman

11. Industry or business

FATHER
12. Name: Oscar Norris
13. Birthplace: Virginia

MOTHER
14. Maiden name: Emma Washington
15. Birthplace: Virginia

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 29, 46 (month) (day) (year)
Cemetery or crematory: Mt Auburn Cem.
Location

18. Funeral director: Elroy O. Wilson
Address: 1010 Brantly ave

19. April 26, 46 (Date rec'd by registrar) Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 26, 1946, at 7:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 9, 1945, to April 26, 1946
and that I last saw him alive on April 26, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	1 year
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: J. B. Lyon M. D. or other
Address: Henryton, Md. Date signed 4-26-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03650

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months, 11 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No. (Glenmont)
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: EUNICE DAVIS OFFETT

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	married

6.(b) Name of husband or wife:

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 8, 1919

8. AGE: Years: 27 | Months: 3 | Days: 11 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Rockville, Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Carroll Matthews
13. Birthplace: Montgomery County, Md.

MOTHER
14. Maiden name: Lavinia Davis
15. Birthplace: Rockville, Md.

16. Informant: I.B. Lyon, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 23 1946 (month) (day) (year)
Cemetery or crematory: norbeck md
Location:

18. Funeral director: Robert L Snowden
Address: Rockville md

19. 4-19- (Date rec'd by registrar) 19 46 Albert R Swanson Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 19, 19 46 at 3:55 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 8, 19 46 to April 19, 19 46 and that I last saw her alive on April 19, 19 46

Immediate cause of death: Pulmonary Tuberculosis — DURATION: 5½ yrs.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: I. B. Lyon M. D.

Address: Henryton, Md. Date signed: 4-19-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03651

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: rural Westminster
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: rural Westminster
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Solenia Ogg

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: John L. Ogg

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 30, 1861

8. AGE: Years	Months	Days	If less than one day
84	10	7	hrs. min.

9. Birthplace: Carroll County, Maryland
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

MOTHER FATHER

12. Name: Isaac Green

13. Birthplace: Maryland

MOTHER

14. Maiden name: Nancy Leppo

15. Birthplace: Maryland

16. Informant: Harry W. Ogg

Address: Westminster, Md.

17. burial
(Burial, cremation, or removal. Which?) Date thereof 4/9/46 (month) (day) (year)

Cemetery or crematory: Deer Park Cemetery

Location: Smallwood, Md.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 4/8 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 6 1946, at 7½ P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from February 1946, to April 6 1946

and that I last saw h[illegible] alive on april 5 1946

Immediate cause of death	DURATION
Pneumonia	4 da.
Lobar	
Gangrene Rt Foot	1 mo.
Arterio Sclerosis	Several yrs.
Due to	
Myocardial Degeneration	6 mos.
Due to	
Decompensation	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. Solenia Speicher M. D. or other

Address: Westminster Md. Date signed: 4/7/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MV

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (70-C)

03652

CERTIFICATE OF DEATH

Reg. Diat. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Carroll
City or town Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME James Albert Ewings

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife —
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 3 1938

8. AGE: Years	Months	Days	If less than one day
7	10	2	hrs. min.

9. Birthplace Carroll Co. Md. (Town, county, and state)
10. Usual occupation None
11. Industry or business

FATHER
12. Name James Arthur Ewings
13. Birthplace Carroll Co. Md.

MOTHER
14. Maiden name Mary Elizabeth Rupprecht
15. Birthplace Carroll Co. Md.

16. Informant James A. Ewings
Address Westminster Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 8 - 1946 (month) (day) (year)
Cemetery or crematory Westminster Cemetery
Location Westminster, Md.
18. Funeral director H Bankard & Son
Address Westminster, Md.
19. 4/6 19 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 19 46 at 4:00 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19 — to — 19 —
and that I last saw h alive on — 19 —

Immediate cause of death A. Fracture, dislocation cervical Vertebra — DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op.
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of Apr 5, 1946
Where did injury occur? Westminster (City or town) Carroll (County) Md (State)
Injured at home, farm, industry, public place (where?) Highway
Means of injury Struck by truck injured at work? No

23. SIGNATURE James T. Monk Deputy Medical Examiner
M. D. or other
Address Westminster Md. Date signed 4/5/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

03653

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months, 20 days
Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1111 W. Saratoga Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: FRANK HORACE PARKER

3.(b) Social Security Number: 218-05-5244

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Lottie Parker
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 22, 1906

8. AGE: Years	Months	Days	If less than one day
39	9	8	hrs. min.

9. Birthplace: Whaleyville, Va. (Town, county, and state)
10. Usual occupation: Presser
11. Industry or business
FATHER 12. Name: Frank Parker
13. Birthplace: Whaleyville, Va.
MOTHER 14. Maiden name: Rosa Hunter
15. Birthplace: Whaleyville, Va.
16. Informant: Deceased
Address

Burial (Burial, cremation, or removal. Which?) Date thereof May 4 1946 (month) (day) (year)
Cemetery or crematory: Mt Calvary.
Location
18. Funeral director: Adolphus Hartsfield
Address 918 Druid Hill Ave
19. 4/30 (Date rec'd by registrar) 19 46 Albert R. Swanbrow Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 30, 1946, at 6.35P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from December 10, 1946 to April 30, 1946 and that I last saw him alive on April 30, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	7 months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: S. D. Lyon M. D. or
Address: Henryton, Md. Date signed: 4/30/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 87

CERTIFICATE OF DEATH

03654

Reg. Dist. No. 7H

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr., 11 mo., 11 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 1 yr., 11 mo., 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Vagrant County:
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Simon Pearl

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: Freda First (?)
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 1, 1889

8. AGE: Years	Months	Days	If less than one day
57	00	6	hrs. min.

9. Birthplace: Russia
(Town, county, and state)
10. Usual occupation: rag dealer (?)
11. Industry or business:

FATHER
12. Name: Jacob Pearl
13. Birthplace: Russia

MOTHER
14. Maiden name: Freda First (?)
15. Birthplace: Russia

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-9-46 (month) (day) (year)
Cemetery or crematory: Mt Carmel
Location: Lorman Hill Rd.
18. Funeral director: Jas. E. Lewis Jr.
Address: 1439 E. Balto St.

19. April 8 1946 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 7 1946 at 9:00 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 2 1944 to April 7 1946 and that I last saw him alive on April 7 1946

Immediate cause of death	DURATION
Parkinson's syndrome, prior to	1926
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May, M.D.
Springfield State Hospital M. D. or other
Address: Sykesville, Maryland Date signed: 4-7-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03655

Reg. Dist. No. 24

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 months, 25 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 10 months, 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Barnesville
(If outside city or town limits, write RURAL and give nearest town)

Street No. ...
(If rural, give LOCATION)

2.(a) If veteran, name war ...

3. (a) FULL NAME

Ella M. Poole

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Rufus Green Poole (deceased)

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): 11/9/1877

8. AGE: Years	Months	Days	If less than one day
68	4	23	... hrs. ... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

MOTHER

12. Name: Lemuel Miles

13. Birthplace: Maryland

FATHER

14. Maiden name: Martha Jane Miles

15. Birthplace: Maryland

16. Informant: Records of Springfield State Hosp.
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-4-46 (month) (day) (year)

Cemetery or crematory: Methodist

Location: Purdum, Md.

18. Funeral director: William B. Hilton

Address: Barnesville, Md.

19. April 2 1946 (Date rec'd by registrar) C. Henry Veer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 2, 1946, at 2:45 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/7/45, 19..., to 4/2/, 1946 and that I last saw her alive on 4/2/, 1946

Immediate cause of death	DURATION
Pulmonary tuberculosis	3 years
Due to:	
Due to:	
Other conditions: Involutional Melancholia,	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Helmut Braun M.D. M. D. or other

Address: Sykesville, Maryland Date signed: 4/2/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03656

Reg. Dist. No. 24

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 yrs. 18 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 4 yrs. 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: City
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1803 Bank St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Eugene A. Pychner

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 6/22/24

8. AGE: Years	Months	Days	If less than one day
21	9	10	hrs. min.

9. Birthplace: Pennsylvania (Town, county, and state)
10. Usual occupation: Helps in tailor shop
11. Industry or business:

FATHER
12. Name: Eugene Pychner
13. Birthplace: Poland

MOTHER
14. Maiden name: Elsie Pelsinska
15. Birthplace: Pennsylvania

16. Informant: Records of Springfield State Hospital
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4 (month) 5 (day) 46 (year)
Cemetery or crematory: Holy Rosary
Location: Baltimore County
18. Funeral director: John M. Weber
Address: 401 S. Chester Street

19. 4/4 (Date rec'd by registrar) 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4/2 19 46 at 11:25 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/5 19 46, to 4/2/ 19 46
and that I last saw h im alive on 4/2 19 46

	DURATION
Immediate cause of death: Pulmonary tuberculosis	3 mos.
Due to:	
Due to:	
Other conditions: Schizophrenia, catatonic type	5 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Helmut Bragen M.D. (M. D. or other)
Address: Sykesville, Maryland Date signed: 4/2/46

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

03657

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Sykesville
(If ontside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr. 1 mo. 2 da.
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 1 yr. 1 mo. 2 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Deerwood
(If ontside city or town limits, write RURAL and give nearest town)
Street No.
(If rnral, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
ALMA LUCILLE REED

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	separated

6.(b) Name of husband or wife Earl Reed
unknown 6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) February 24, 1910

8. AGE: Years	Months	Days	If less than one day
36	1	9	hrs. min.

9. Birthplace Deerwood Maryland
(Town, county, and state)
10. Usual occupation housework
11. Industry or business home
FATHER 12. Name Thomas T. Mullican
13. Birthplace Maryland
MOTHER 14. Maiden name Gertrude Butt
15. Birthplace Maryland
16. Informant Hospital Records
Address Sykesville, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/4/46 (month) (day) (year)
Cemetery or crematory Forest Oak Cemetery
Location Gaithersburg, Md.
18. Funeral director Ernest L. Gaither
Address Gaithersburg Md.
19. April 2 1946 C. Abbey Weis
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1946, at 2 P M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 1, 1945, to April 2 1946
and that I last saw her alive on April 2, 1946

Immediate cause of death	DURATION
Bronchopneumonia	4 da.
Due to	
Due to	
Other conditions Psychosis with Mental Deficiency (Include pregnancy within 3 months of death)	15 yrs.

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Maud M Rees M.D.
M. D. or other
Address Sykesville Md Date signed 4-2-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

03658

CERTIFICATE OF DEATH

Reg. Dist. No. 71

1. PLACE OF DEATH:

County: Carroll

City or town: Hunterstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Hunterstown
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Walter Luther Rentzel Jr

3.(b) Social Security Number: 219-20-4492

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Truth Hannah Rentzel

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 29 - 1919

8. AGE: Years: 26 Months: 9 Days: 27 If less than one day: ..... hrs. ..... min.

9. Birthplace: Carroll Co. Maryland
(Town, county, and state)

10. Usual occupation: Farmer - Woodworker

11. Industry or business: Defense Plant

FATHER
12. Name: Walter L. Rentzel
13. Birthplace: Maryland

MOTHER
14. Maiden name: Edna Rentzel Slick
15. Birthplace: Maryland

16. Informant: Walter L Rentzel
Address: Hunterstown Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 29 - 1946 (month) (day) (year)

Cemetery or crematory: Lutheran Cemetery

Location: Hunterstown Maryland

18. Funeral director: D D Shorb & Son

Address: Elmer Bridge & New Windsor, Md.

19. April 29 1946 (Date rec'd by registrar) Margaret R. Englar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 26 1946 at 11.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1943 to Apr. 26 1946

and that I last saw him alive on Apr. 26 1946

Immediate cause of death	DURATION
Diabetes	3 Yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or Other

Address: Johnsville Date signed: 4-27

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Evidence for change of age birth date of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (89-a)

03659

FILM No. I 04 MAY 15 1946

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Carroll
City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME A. Louise Roloson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 12, ~~1880~~ 1887

8. AGE: Years	Months	Days	If less than one day
59 ~~66~~	0	17	..... hrs. ..... min.

9. Birthplace Md. (Town, county, and state)

10. Usual occupation None.

11. Industry or business

FATHER 12. Name J. Otis Roloson
13. Birthplace Md.

MOTHER 14. Maiden name Anna L. Codling
15. Birthplace Md.

16. Informant Mrs. J. J. Wilson
Address Balto. Md.

17. Burial (Burial, cremation, or removal—Which?) Date thereof May 2, 1946 (month) (day) (year)

Cemetery or crematory Loudon Park Cem.

Location Balto. Md.

18. Funeral director Williams Cook, Inc.

Address 1217 St. Paul St.

19. April 30 1946 (Date rec'd by registrar) C. Henry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/29 1946, at 10:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/23 1946, to 4/29 1946, and that I last saw h... alive on 4/29 1946

Immediate cause of death	DURATION
Cerebral Hemmorage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. A. Bamm M.D.
M. D. or other

Address Sykesville Md. Date signed 5/3 1946

VS-AIB 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

*03660 (77) Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Westminster - Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs
Hospital, institution, or street address where death occurred: Carroll Co. Home
How long in hospital or institution? 3 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Westminster - Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Carroll Co. Home
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3. (a) FULL NAME Edward Frank Ruby

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widower

6.(b) Name of husband or wife: Annie Ruby
6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): March 16 - 1881

8. AGE: Years: 65 | Months: 1 | Days: 2 | If less than one day: ... hrs. ... min.

9. Birthplace: Md (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Jesse Ruby
13. Birthplace: Md

MOTHER
14. Maiden name: Emeline Leppo
15. Birthplace: Md

16. Informant: Mrs Jesse Ruby
Address: Hampstead Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 20 '46 (month) (day) (year)
Cemetery or crematory: St Paul's
Location: Arcadia, Baltimore Md

18. Funeral director: Edel & Tipton
Address: Hampstead Md

19. April 19 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 18 1946, at 6:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-14- 1946, to 4-18 1946
and that I last saw h... alive on 4-18- 1946

Immediate cause of death	DURATION
Cerebral hemorrhage	5 days
Due to: Arterio sclerosis	15 yrs (?)
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: N.O. Date of op.: ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: N.O. Date of: ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ...
Means of injury: ... Injured at work?

23. SIGNATURE: W. L. Stone M. D. or other
Address: Westminster Md Date signed: 4-18-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03661

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 yr. 3 mo. 22 da.
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 16 yr. 3 mo. 22 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: .....
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. .....
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3.(a) FULL NAME: Harry W. Rudolph.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	single

6.(b) Name of husband or wife .....
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 7, 1879

8. AGE: Years	Months	Days	If less than one day
67		15	..... hrs. ..... min.

9. Birthplace: Baltimore City (Town, county, and state)
10. Usual occupation: Worked in pill dept.
11. Industry or business: Drug factory-Sharpe & Dohme

FATHER
12. Name: Charles J. Rudolph
13. Birthplace: Maryland

MOTHER
14. Maiden name: Annie M. Carr
15. Birthplace: Maryland

16. Informant: Springfield State Hosp, records.
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 24th (month) (day) (year)
Cemetery or crematory: Lorraine Park
Location: Rural
18. Funeral director: Millert Funeral Home
Address: 200 S Arlington St

19. 4-22 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 22 1946 at 2:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1943 to April 22 1946
and that I last saw him alive on April 21 1946

Immediate cause of death	DURATION
Chronic myocarditis and myocardial degeneration	6 mo.
Due to:	
Due to:	
Other conditions: Manic-depressive psychosis, manic type	18 yr.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Robert Bertrand May, M.D.
Springfield State Hospital M.D. or other
Address: Sykesville, Maryland Date signed: 4-22-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-0

CERTIFICATE OF DEATH

★ 036627 6

Reg. Dist. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 yrs

Hospital, institution, or street address where death occurred:

Carroll County Gen. Hosp.

How long in hospital or institution? 13 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. 128 W Main

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Laura L. Shreve

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widow

6.(b) Name of husband or wife Joseph E. Shreve

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 27 - 1854

8. AGE:

Years	Months	Days	If less than one day
91	3	18	..... hrs. ..... min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER

12. Name Samuel Brumbaugh

13. Birthplace Carroll Co. Md.

MOTHER

14. Maiden name Christina Futterlinger

15. Birthplace Md.

16. Informant W. H. Davis

Address Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 17-1946 (month) (day) (year)

Cemetery or crematory Westminster Cem.

Location Westminster, Md.

18. Funeral director H. Bankard & Son

Address Westminster Md.

19. 4/17 (Date rec'd by registrar) 19 46 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16th 1946, at 7.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1st 1946 to April 16th 1946 and that I last saw her alive on April 16th 1946

Immediate cause of death Cerebral Hemorrage — DURATION .....

Due to ..... DURATION .....

Due to ..... DURATION .....

Other conditions ..... DURATION .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE John J. Stewart M. D. or other

Address Westminster Date signed April 18 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-D)

CERTIFICATE OF DEATH

03663 P

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 38 yr., 1 mo., 25 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 38 yr., 1 mo., 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: John T. Smith

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife: none
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 5, 1884

8. AGE: Years	Months	Days	If less than one day
61 (?)	7	11	hrs. min.

9. Birthplace: Baltimore Maryland (Town, county, and state)
10. Usual occupation: laborer
11. Industry or business

FATHER
12. Name: Joseph Smith
13. Birthplace: Baltimore Maryland

MOTHER
14. Maiden name: Margaret Minick
15. Birthplace: Baltimore Maryland

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 19/46 (month) (day) (year)
Cemetery or crematory: Mt Carmel
Location: Baltimore
18. Funeral director: Philip Henry Sons
Address: 2024 Orleans St

19. 4-17 19 46 (Date rec'd by registrar) A.W. Hedrick per adk Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 15 19 46, at 8:00p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 19 43, to April 15 19 46 and that I last saw him alive on April 15 19 46

Immediate cause of death	DURATION
Chronic myocarditis and myocardial degeneration	2 yrs.
Due to	
Due to	
Other conditions: Schizophrenia	40 yrs.

(Include pregnancy within 8 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Robert Bertrand May, M.D.
Robert Bertrand May, M.D.
Springfield State Hospital M. D. or other
Address: Sykesville, Maryland Date signed: 4-15-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

03664

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 2624 Flora Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: JOHN LEE SPENCER

3.(b) Social Security Number: 216-24-5846

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 27, 1929

8. AGE: Years	Months	Days	If less than one day
16	4	16	hrs. min.

9. Birthplace: Patrick County, Va.
(Town, county, and state)
10. Usual occupation: Student
11. Industry or business:

FATHER
12. Name: Henry Carter
13. Birthplace: Unknown

MOTHER
14. Maiden name: Daisy Cannon
15. Birthplace: Patrick County, Va.

16. Informant: I.B. Lyon, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/17/46 (month) (day) (year)
Cemetery or crematory: Mt. Zion Cemetery
Location: 321 & Street
18. Funeral director: Katie R. Williams
Address: Baltimore Md.

19. April 13, 1946 (Date rec'd by registrar) Albert R. Swanborg Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 13, 1946, at 10:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 22, 1946, to April 13, 1946 and that I last saw him alive on April 13, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	4 months
Due to: Tuberculous Meningitis	1 week
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: I.B. Lyon M. D. or other
Address: Henryton, Md. Date signed: 4-13-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (49-a)

03665 P

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 years, 9 months, 3 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 8 yrs.; 9 mo., 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 738 Linnard Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Edna E. Stange

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 15, 1895

8. AGE: Years	Months	Days	If less than one day
50	11	27	hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER — 12. Name: William Stange
13. Birthplace: Maryland

MOTHER — 14. Maiden name: Emma Scheplich
15. Birthplace: Maryland

16. Informant: Hospital record
Address: Springfield State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 13-1946 (month) (day) (year)
Cemetery or crematory St. Matthews Cemetery
Location Baltimore

18. Funeral director: Maurice L. Syfert
Address: 600 N. North Ave

19. 4/12/46 (Date rec'd by registrar) A.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 11, 1946 at 3.15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1 1942, to April 11 1946
and that I last saw her alive on April 11 1946

Immediate cause of death	DURATION
Carcinoma of the left ovary	6 months
Due to:	
Due to:	
Other conditions: Psychosis with mental deficiency	24 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: Tumor of left ovary
Date of op. 11-29-45

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Irene H. Tolman, M.D. (M. D. or other)
Address: Springfield State Hosp. Date signed: 4-11-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

03666

Reg. Dist. No. 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs 4 mo 18 da

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 2 yrs 4 mo 18 da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: /
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME J. Carroll Steinbach

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	divorced

8.(b) Name of husband or wife: —

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov 1880

8. AGE:

Years	Months	Days	If less than one day
65	5	—	..... hrs. ..... min.

9. Birthplace: Md.
(Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business: Insurance

FATHER
12. Name: John L. Steinbach
13. Birthplace: Germany

MOTHER
14. Maiden name: Katherine Elizabeth Neubarr
15. Birthplace: Germany

16. Informant: John L. Steinbach
Address: 2406 Maryland Ave Balto.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 15 1946 (month) (day) (year)

Cemetery or crematory: Loudon Park

Location: Baltimore, Md.

18. Funeral director: Wm Cook Inc

Address: 120 St Paul St Balto Md

19 April 12 1946 C. Harry Weis
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 12 1946, at 1252 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 25 1924, to April 12 1946 and that I last saw h... alive on April 12 1946

Immediate cause of death	DURATION
Bronchopneumonia	2 da
Due to: Cerebral Hemorrhage	
Due to:	
Other conditions: Hypertension	2

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. H. Maston M.D.
M. D. or other

Address: Sykesville Md. Date signed: 4/12/46

03667

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 72 Pennsylvania Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: none

3.(a) FULL NAME: Frank Eli Stimax

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Emma V. Stimax

6.(c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): January 17, 1871

8. AGE: Years	Months	Days	If less than one day
75	3	9	....hrs. ....min.

9. Birthplace: Carroll County, Maryland
(Town, county, and state)

10. Usual occupation: labor

11. Industry or business

FATHER — 12. Name: Isaac Stimax

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Emily J. Stimax

MOTHER — 15. Birthplace: Maryland

16. Informant: Paul Stimax

Address: Westminster, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 4/29/46 (month) (day) (year)

Cemetery or crematory: Wesley Cemetery

Location: near Hampstead, Md.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 4/27 1946 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 26, 1946, at 6.30p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 25 1946, to April 26 1946

and that I last saw h[illegible] alive on April 26 1946

Immediate cause of death: Coronary occlusion — DURATION: + 3 mos.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reese Wilkens M D
M. D. or other

Address: Westminster Md Date signed: 4/27/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

03668

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23rd)

CERTIFICATE OF DEATH

Reg. Diat. No. 76

1. PLACE OF DEATH:
County: Carroll
City or town: Westminster R. D. I
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
Westminster R. D. I
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Westminster R. D. I
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Clarence Thomas Stonesifer

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ella Stonesifer
6.(c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): October 12 1875

8. AGE: Years	Months	Days	If less than one day
70	6	8	hrs. min.

9. Birthplace: Carroll Co. Md.
(Town, county, and state)
10. Usual occupation: Retired Farmer
11. Industry or business: Farm

FATHER
12. Name: Joseph Stonesifer
13. Birthplace: Carroll Co. Md.

MOTHER
14. Maiden name: Catherine Miller
15. Birthplace: Carroll Co. Md.

16. Informant: Mrs. Clarence Stonesifer)
Address: Westminster, Md. R. D. I

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 23 1946 (month) (day) (year)
Cemetery or crematory: Pleasant Valley Cemetery
Location: Pleasant Valley Md.
18. Funeral director: F. M. Little & Son
Address: Littlestown, Pa. Per K. A. Little

19. 4/21/1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 20 1946 at 4:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 30 1945 to April 20, 1946 and that I last saw him alive on April 19, 1946

Immediate cause of death	DURATION
Cerebral hemorrhage	4 days
Due to: Cardio-vascular disease	10 years
Due to:	
Other conditions: Previous hemiplegia	6 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: C. Reese Wilkens M. D. or other
Address: Westminster, Md. Date signed 4/20/1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-D)

03669

CERTIFICATE OF DEATH

★ Reg. Dist. No. 16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Westminster (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 32 years
Hospital, institution, or street address where death occurred: Charles St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster (If outside city or town limits, write RURAL and give nearest town)
Street No. Charles St. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Amaza Warner

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
f.	Col.	Widowed

6.(b) Name of husband or wife Charles Warner
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years: About 65 | Months | Days | If less than one day: hrs. min.

9. Birthplace Lexington Virginia (Town, county, and state)
10. Usual occupation House-servant
11. Industry or business
FATHER 12. Name ? Holt
13. Birthplace
MOTHER 14. Maiden name ?
15. Birthplace
16. Informant Ernest H. Holt (son)
Address Charles St. Westminster
17. Burial (Burial, cremation, or removal. Which?) Date thereof April 26 46 (month) (day) (year)
Cemetery or crematory Elkwood Cemetery
Location Westminster, Md.
19. Funeral director J. E. Myers, Jr.
Address Westminster, Md.
19. 4/25 19 46 L.K. Woodward (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23, 1946, at 3 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 31, 1945 to Apr. 23, 1946 and that I last saw her alive on April 16 1946

	DURATION
Immediate cause of death: Myocardial degeneration	8 mos
Due to: Cardio vascular hypertensive disease	Indefinite
Due To:	
Diher conditions: Chronic nephritis	"

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. Reese Wilkens, M.D.
Address Westminster M. D. on other Date signed 4/24/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03670

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 23 days

Hospital, institution, or street address where death occured: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1709 N. Dallas Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: ETHEL WATSON

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 17, 1914

8. AGE: Years	Months	Days	If less than one day
31	3	26	hrs. min.

9. Birthplace: Unknown (Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER — 12. Name: Unknown

FATHER — 13. Birthplace: Unknwon

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: Unknown

16. Informant: I. B. Lyon, M. D.

Address: Henryton, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof april 17. 1946 (month) (day) (year)

Cemetery or crematory: Mt. Calvary

Location: annapolis Rd.

18. Funeral director: Mrs Robert Elliott Houghton

Address: 1129 N. Caroline St.

19. 4/13 (Date rec'd by registrar) 19 46 Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 13, 19 46 at 1.00P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 20, 19 46 to Apr. 13, 19 46 and that I last saw her alive on April 13, 19 46

Immediate cause of death	DURATION
Pulmonary Tuberculosis	1 year
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: I. B. Lyon M. D. or other

Address: Henryton, Md. Date signed: 4/13/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15